VOL. 17, NO. 1 JULY-SEPT., 1967



# Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

# N. C. ALCOHOLIC REHABILITATION CENTER

# BUTNER, N. C.

### About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

### A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

### Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

### Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $120 is payable at the time of admission. Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

### Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

# N. C. DEPARTMENT OF MENTAL HEALTH

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# INVENTORY


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*Popular acceptance of a custom does not cancel its dangers.*

# ALCOHOL and ACCIDENTS

**BY HERMAN E. KRIMMEL**
DIRECTOR
CLEVELAND CENTER ON ALCOHOLISM
CLEVELAND, OHIO

FOR several years the highways of America have been lined with signs warning: 'If you drink, don't drive. If you drive, don't drink." Most authorities applaud the wisdom of this advice while deploring the fact that it is more honored in the breach than the observance.

It probably never had a chance since the majority of adult Americans drink and the majority of adult Americans drive. The mixture of the two seems inevitable since many adult social functions involve alcoholic beverages and people arrive and leave by automobile. The custom is condoned at all levels of society and is unlikely to be changed by roadside placards. Popular acceptance of a custom, however, does not cancel its dangers.

As in all areas of drinking behavior, it is possible to find a variety of statistics relating to alcohol and accidents and they do not all agree. There is little uniformity used in compilation, there is no single definition of a drinking driver and it can seldom be said with certainty that the presence of alcohol in any accident makes it the major factor in that accident.

Nevertheless, the most reliable surveys during the past decade show a consistency that compels acceptance of the hypothesis that alcohol is a significant factor in traffic accidents. In one of the earliest studies of alcohol and traffic in 1938, nearly half of 270 drivers involved in accidents were found to have taken alcohol as compared with one in eight of a control group of 1,750 drivers. The blood alcohol level exceeded 100 mg percent in 22 percent of the former and only 1 percent of the latter. A Los Angeles study during 1949-1951 revealed that about a third of all victims in fatal traffic accidents had taken alcohol and a New York report in 1962 indicated that at least 50 percent of fatal accidents involved drivers with a high blood alcohol level.

Incidentally, intoxicated pedestrians are a serious accident hazard. One survey revealed that 25 percent of 2,500 pedestrians killed in traffic accidents had been drinking.

The effects of alcohol—even a little—are incompatable with good driving. Almost invariably judgment is impaired and inhibitions are relaxed. This leads to faulty estimates of distance and space. Moreover, the driver who has had "only a few" tends to abandon normal precautions. He presses carelessly on the accelerator, passes when other cars are approaching and monopolizes the right of way. His confidence seems to expand in direct ratio to his decreasing ability.

Reflexes are slowed by alcohol. Our knowledge in this area is certainly incomplete but the majority of studies indicate people tested after ingestion of alcohol have shown impaired performance in muscular skill, sensory acuity, memory and other psychological functions. These effects are insidious and their lethal potential can be measured in split seconds. For example, if a brake pedal is hit only a half second later while driving at 60 miles per hour, the car will have gone an additional 44 feet.

Vision is diminished, especially side vision. Because of the constriction of

Reprinted from the *News*, a publication of the Cleveland Center on Alcoholism.

visual fields, a drinking driver may fail to see a car suddenly appearing from a side street.

Paradoxically, the alcoholic, when he is drinking heavily, may be less dangerous than the social drinker who has had only a few. The former does not usually get into a car to drive because he can't. If he does try, he is frequently restrained by others. Obviously, if a saturated alcoholic does manage to start a car, he is a potential killer but, even then, the erratic behavior of the automobile may quickly attract attention and lead to an arrest.

In his book, **Behaviour in Uncertainty,** John Cohen points out that there is some evidence that the proportion of serious or fatal accidents is greater when the blood alcohol is relatively low. Morever, "the disturbing effects of alcohol in the blood are more marked when the concentration of alcohol is increasing than it is on the decline; and they are greater when the concentration is increasing **rapidly** than it is increasingly **slowly.**"

Any amount of alcohol is, of course, potentially dangerous in driving. The effects, however, vary with individuals and can vary with the same individual at various times. The number of drinks can never be the sole criterion but anyone who takes two drinks within a few minutes before driving is a traffic hazard. It is worth noting that commercial airline pilots are required to abstain from drinking for at least 18 hours before flying.

Experienced drinkers can probably adjust to alcohol better than light drinkers or those who have just started to drink. Cohen reports on tests that were made of the degree of impairment in skill after taking alcohol, in abstainers, moderate drinkers and heavy drinkers respectively. Six tests were given, before and after drinking, and all three groups showed impairment at levels above 100 mg percent. At lower levels, however, the abstainers showed most and the heavy drinkrs least effect, the differences between the groups being greatest at blood alcohol levels less than 50 mg percent.

It is also true that well established skills are less likely to be impaired than newly acquired skills. This may account for the relatively high accident rates among teen-agers because they are unaccustomed to drinking and their driving skills are recently learned.

Despite variations in individual reactions, blood alcohol level is considered the most reliable test avilable to law enforcement authorities. In most states a level of 0.15 (1½ drops of alcohol in 1,000 drops of blood) is accepted as **prima facie** evidence that one is under the influence of alcohol. This is regarded as far too lenient by many and there is considerable pressure to amend the Uniform Motor Vehicle Code to reduce the presumptive statutory level to 0.10 percent.

North Dakota was the first state to follow this recommendation. New York has created an offense know as "driving while in an impaired condition" which is a lesser offense than "driving while intoxicated."

What can be done about this national peril? As Dr. Paul Joliet of the U. S. Public Health Service has pointed out, stringent legislation has been largely ineffective because too many people identify with the drinking driver instead of the non-drinking driver. Moreover, many who drink and drive—and have done so for years without mishap—cannot believe that they are a risk when doing so and are not, therefore, in sympathy with severe legal restrictions and penalties.

The responsibility, then, lies to a considerable degree with educators and parents who, says Dr. Joliet, "are primarily concerned with instilling not only knowledge but also the attitude which will permit knowledge to be applied effectively."


**Hospital Program**

War Memorial Hospital would like to be placed on your free mailing list for *Inventory*. We have an alcoholic rehabilitation program.

Mary E. Babington
Social Worker
Sault Ste. Marie, Michigan

**Aids Tuberculosis Hospital**

We would very much appreciate being continued on your mailing list. Our tuberculosis hospital has a census of 200 patients; approximately 40 per cent of our patients have a diagnosis of alcoholism along with their tuberculosis. Your magazine has helped our employees gain a broader understanding of the patient's drinking problem and has enabled them to work more effectively in assisting the patient toward his recovery.

Katherine Richeson, R.N.
Assistant Supervisor
Personnel Education
Firland Sanatorium
Seattle, Washington

**Problem Drinker**

My husband is a problem drinker who won't admit he has a problem. I want to learn what I can so I can help. Thanks for the literature.

Anonymous
Williamston, N. C.

**Temperate Use and Education**

Your publication is excellent and I feel that it is doing much good. We, in the Durham County Alcoholic Beverage Control System, are very much interested in the cause of temperate use of alcoholic beverages, and in education concerning alcohol and its dangers — especially among youth.

Please send my copy of *Inventory* to my home address.

Wyatt T. Dixon
Durham, N. C.

**Five Addictions**

I have read with interest and concern your fine article on food and alcohol in the April-June edition, and certainly agree that excessive use of both have many similarities.

It seems to me that we have five great addictions in America, listed as follows: (1) Tobacco. (2) Drugs-Narcotics. (3) Alcohol. (4) Food. (5) Work.

The big difference is that there is a choice in the first three and there is no choice in the last two. The main factor that the writer neglected to point out is that everyone has to eat and work, but smoking, etc. are chosen and begun by free will and decision. Without drinking there can be no alcoholism.

An Interested Churchman
Roanoke, Virginia

*Editor's Note*

*The main factor that the above writer (whose name was withheld by the editor) failed to point out is that a person may choose to drink without choosing alcoholism, or to smoke without choosing cancer, or to take the tranquilizer the doctor prescribed without choosing to become addicted to it. Nevertheless, as the writer said, if you don't drink you certainly won't have alcoholism. Unfortunately, however, not drinking won't guarantee that you won't have some other emotional illness.*

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

*The director of these tests now believes that the available data would support .05 per cent as the minimum blood alcohol level indicating impairment in most drivers.*

# POINT ZERO EIGHT

**BY ALASDAIR McCRIMMON**

A drinking-driving test conducted for a network television film special, CTV's *Point Zero Eight,* has cast further doubt on the view that .08 per cent can safely be taken as the minimum blood alcohol level that should legally constitute impairment.

H. Ward Smith, Ph.D., director of the Ontario government's Centre of Forensic Sciences and an associate professor of pharmacology at the University of Torondo, who directed the test last November for the privately owned network, said in the films that his findings had made him change his own mind about the minimum danger level.

Professor Smith had appeared as an expert witness in the spring of 1966 before a House of Commons committee that was considering the Canadian Bar Association's proposal to establish .08 per cent as the legal impairment level. At that time, he told narrator Ed McGibbon that he believed the available data would not support .08 as indicating impairment in most drivers. After evaluating the results of the test, he appeared before the committee again at his own request to say that he now believed that .08 was probably too high, and that a safer minimum would be .05.

The difference between .05 and .08 per cent in terms of alcohol consumed, is just about the difference between two and three drinks. If a 160-pound man were to drink two ordinary-size drinks of beer, wine or hard liquor—in a few minutes, his blood alcohol level would rise to just about .05 per cent; if he made his two drinks last an hour, his level would stay down well below .05 (closer to .03 which is not considered to impair

This article is reprinted by permission from *Addictions,* a publication of the Addiction Research Foundation of Ontario, Canada. Its author, Alasdair McCrimmon, is editor of this quarterly magazine.

The film, *Point Zero Eight,* may be purchased from Film House Limited, 22 Front Street East, Toronto, Canada. Also the CTV Television Network Ltd., 42 Charles Street East, Toronto 5, Canada has two prints which it loans out to various organizations for periods up to one week. The only requirement for buying or borrowing is confirmation that the film will be used strictly for educational and non-profit purposes. For additional information, write to one or both of the above addresses.

most drivers).

If he were to take three drinks in a few minutes, his blood alcohol level would soar to nearly .08; he would have to space the three drinks over about two hours to keep it below .05. Four drinks would give him a blood alcohol level of about .10 if he drank them one on top of the other; he would have to make four drinks last about three-and-a-half hours to keep it below .05.

Professor Smith told us that the idea for the *Point Zero Eight* film originated when CTV representatives asked him if he would design a demonstration that they could film for television to illustrate the effects of drinking on drivers. In a report of the tests, issued by CTV as a handout, Professor Smith said: "The unique features of this study are that racing drivers were used and speeds of up to 60-70 miles per hour formed part of the tests."

Professor Smith and an assistant, D. M. Lucas, M.Sc., collaborated with Paul Cooke, manager of the Canadian Comstock Racing Team, to devise a series of tests that would show "changes in judgment, attitude and skill." They set up the course at Harewood Acres Race Track, on the site of the wartime RCAF station at Jarvis, Ontario, about twenty miles southeast of Brantford.

"Racing drivers were used," Professor Smith said in his report, "because it was thought that at the concentrations of alcohol involved, their skill would not be so markedly affected that they could get into a serious accident situation. The tests were scored on a two-page sheet which listed some fifty items, which indicated various departures from the ideal driving pattern. Mr. Cooke was able to get two skilled drivers and racing instructors who, with himself, formed a team of three observers. These were Bob Hanna and Richard Shelton. The drivers were Al Pease, Warner Gudzus, Ludwig Heimrath, Ian Hart, Lloyd Howell, Craig Hill, Diana Carter, and Zigrund Gudzus. These drivers have all won trophies consistently in Canadian racing.

## *Changes in driving ability*

"The procedure was to have the drivers, after being instructed to drive safely and within their limits, drive the track several times for practice. They drove the two-mile track four times, in what we referred to as the 'dry runs.' on which they were scored. They were then interviewed to determine their drinking history and to assess how much alcohol it would be safe to give them in relation to their stated tolerance. They then drank the amount agreed on in a one-hour period. An additional hour elapsed so that this alcohol would be absorbed. They went back on the track and drove the track four more times, which we refer to as the 'wet run.' The alcohol level was measured before and after the 'wet runs' using the Breathalyzer.

"Some of these drivers were retested so that after their 'wet runs,' they came back to the refreshment stand, drank for another hour, allowing an hour for absorption of alcohol, and were tested at various higher levels. It was thought that this arrangement would allow for a suitable measure of driving skill normal to this situation, and a suitable test of any change after alcohol.

"In summary, the results were dramatic and showed things which we had no reason to expect. The most notable finding appeared to be a failure to sense the attitude or po-

***ccurred at blood alcohol levels between .04 and .08 per cent.***

sition of the car. This showed especially on curves, and is connected with the deep muscle sense which is the balancing mechanism of the body. Since there was a reduction in this feeling, the driver reacted to visual clues, which only come after something has happened. Therefore his driving response is late and usually exaggerated. This gives a weaving and, at a speed, a choppy action of the car. This occurred to some extent at all levels studied down to a reading of .04 per cent.

"In this study, changes in driving ability were shown in all of the drivers at levels between .04 and .08 per cent. With three drivers the blood alcohol levels were taken to higher levels of .10, .13 and .15 per cent. The results at these higher levels were even more prominent in terms of impairment in driving ability.

"In addition to the loss of deep muscle sense, there were general observations in all of the subjects. These have been summarized by Mr. Cooke who was in charge of the small team of observers. These include an increase in speed; an overapplication of brakes; a tendency to wander out of their lane; misjudgment of their distances when stopping and turning; an inability to quickly cancel any reaction when started; more easily distracted; and inability to sense speed except when accelerating. There was also a general complaint that things were happening too fast. This was apparent in all, in that they appeared to be driving behind the car rather than ahead of it. This is notable because racing drivers need to plan far ahead of the car and are quite accustomed to doing this."

The driving behavior Mr. Cooke observed from his position beside the driver bears some resemblance to the driving behavior that suggests impairment to the trained police patrol officer on the highway. A pamphlet called *The Way to Go,* published by the Kemper Insurance Group of Chicago, quotes instructions issued to the California Highway Patrol. These are the deviations from normal driving they are instructed to watch for:

—driving unreasonably fast; driving unreasonably slowly; driving in spurts—slowly, then fast, then slowly;

—frequent lane-changing with excessive speed;

—improper passing with insufficient clearance; taking too long or swerving too much in passing—this suggests over-control;

—overshooting or disregarding traffic control signals; approaching signals unreasonably fast or slowly, and stopping or attempting to stop with uneven motion;

—driving at night without lights; delay in turning lights on when starting from a parked position; failure to dim lights to oncoming traffic;

—driving in lower gears without apparent reason, or repeatedly clashing gears;

—jerkily starting or stopping;

—driving too close to shoulders or curbs, appearing to hug the edge of the road, or continually straddling the centre line;

—driving with windows down in cold weather; and driving or riding with head partly or completely out

(Continued on page 10)

# What's brewing?

**A feature designed to help you keep posted on developments in the field of alcoholism.**

**SEATTLE, WASHINGTON:** The Association of Halfway House Alcoholism Programs of North America, Inc. will hold its 2nd annual conference October 22-25 at the Olympic Hotel. Host to the 1967 Conference will be Pioneer Fellowship House, a Seattle alcoholism halfway house for men. The organization was estabilshed in 1966 as a non-profit, educational-research corporation in Minnesota. Its purpose is to bring together people engaged in the operation of halfway houses for addictive persons. Its present membership includes representation from 20 states and two Canadian provinces. Between 300 and 400 halfway houses are expected to be represented at the conference.

**AN INDUSTRY SURVEY:** A study of more than 900 employees of the Du Pont Company has shown that heavy drinkers were more likely than non-drinkers to develop chronic degenerative diseases, according to a report in **Recovery,** newsletter of the Ayerst Laboratories. Hypertension was more than twice as prevalent among drinkers; cirrhosis of the liver, almost 30 times. Stomach ulcer and cerebrovascular disease rates were almost twice as high in the drinking group; gout and asthma, 70 per cent higher; diabetes and neuritis, 60 per cent; nephritis, 50 per cent; duodenal ulcer, 40 per cent, and chronic bronchitis and coronary heart disease, 30 per cent. No significant differences in prevalence were found for gall bladder disease, benign prostatic hypertrophy, prostatitis, emphysema, or arthritis. Kidney stones were more prominent among the non-drinkers. The investigators, C. A. D'Alonzo, M.D., medical director, and Sidney Pell, Ph.D., biostatistician, of the Du Pont Medical Division, pointed out that "although alcoholics may show a higher prevalence of certain diseases than do non-alcoholics, it does not necessarily follow that alcohol itself plays a direct role in their pathogenesis." The diseases may be caused by such factors as nutritional deficiencies, the use of other stimulants or depressives, anxieties and tension leading to psychosomatic disorders, or a disorderly way of life accompanied by neglect of basic health habits.

**CALGARY, ALBERTA, CANADA:** The Division of Alcoholism, Calgary Centre and radio station CKXL sometime ago conducted a traffic safety experiment called "Operation Save-A-Life." Its object was to prove to the motoring public that drinking can hinder a person's ability to drive, even when he doesn't appear to be intoxicated. The experiment was conducted and broadcast live on a day in December from 2:00-8:00 p.m. Participating experts included a Royal Canadian Mounted Police and a Calgary City Police sergeant, a psychologist from the University of Calgary and representatives of the Division on Alcoholism.

On the day of the experiment, two CKXL announcers were subjected to a series of physical, psychological and driving tests just prior to 3:00 p.m. Beginning at 3:15 p.m. both men were given liquor in controlled amounts.

Additional liquor was administered at half-hour intervals, and both men were tested again throughout the afternoon and evening. By 6:30 p.m. both men had consumed 12 ounces of beverage alcohol, and each registered a reading of .10 in a breathalizer test administered by the R.C.M.P. At this point the men received their final tests.

Even after one or two drinks, a deterioration in response was noted. At the .10 level, both men registered a sharp drop in blood pressure and pulse rate. In even the simplest psychological tests, there was a substantial deterioration in the abilities of both men. One man came within one point of failing a test to identify a series of primary colors. Both men experienced a drop of 20 degrees in the range of their peripheral vision. Both men failed the final driving test. However, their reactions were very different. One drove fast and recklessly. The other drove slowly and cautiously, but still knocked over 4 of the 7 pylons he was required to pass on a serpentine course. Neither man showed signs of being what would commonly be called "drunk." The only effect showed by one was some flushing of the face. The other showed slightly more effect, including facial flushing, some drooping of the eyelids, a tendency to laugh more readily than normal. Both men, however, were able to participate in the programme and discuss their conditions intelligently. Although both men were confident before the experiment that they could drive safely after drinking, both admitted at the conclusion that they could not drive safely.

**INTERNATIONAL A.A.:** The next international A.A. convention will be held July 3-5, 1970 at Miami Beach's Fontainebleau and Eden Roc hotels and Convention Hall, according to Dr. John Norris, non-alcoholic chairman of the General Service Board of Alcoholics Anonymous. He said A.A. now has an estimated membership of over 350,000 with 13,279 autonomous groups in 90 countries which hold more than 16,000 meetings each week. This year A.A. seems to be "fermenting" for the first time behind the Iron Curtain, Dr. Norris said. "However, since the native word meaning **anonymous** also implies **secret** or **conspiratorial,** the members call themselves a name which means 'Alcoholics Unknown.'" A.A., at this meeting, will be celebrating the 35th anniversary of its founding. International conventions are held by A.A. every five years. This will be the first in Southern U.S.A.

**COUNSELOR'S CORNER:** Robert J. Appell, executive director of the Jackson Area Council on Alcoholism, Jackson, Tennessee, finds the following to be very useful advice when he is counseling alcoholics: "I am about to give you a small gift, which will remind you of what you have just told me about yourself—that you know that you can't drink any more. It's this small marble, which fits in your pants pocket where you can touch it—a reminder that you can no longer drink. It will help give you moral support when you need it.

"But this marble isn't magic. It may be that you are one of those unfortunates for whom the temptation to drink is just too overwhelming. So, if you know you are no longer going to fight temptation, give in, because you need to save your strength to recover from your binge.

"Here's what you do. If it looks like you're going to be a loser, go to a bar. But before you enter the bar, take this marble out of your pocket and throw it away as far as you can throw it. Then go into that nice, comfortable, air-conditioned bar and order your favorite drink, with the added knowledge that now, you have lost **all** your marbles."

Mr. Appell has given away almost 5,000 marbles in the past three years. Apparently very few of these have been thrown away, because every day he sees a few of his small gifts lifted in the air in salute to him by grateful former clients. — from the **N.C.A. Newsletter**

of the window.

Paul Cooke told us that the test course had been set up to a standard of difficulty that would ensure that the best of the test drivers would make some errors, even on the dry runs. This ensured a meaningful scoring spread for the drivers on the dry runs. On the wet runs, the skill of the drivers was such that a meaningful scoring spread could still be obtained. He said that the average driver would probably have done as badly on the dry runs as the test drivers did on the wet runs, and would not have completed the wet runs at all.

Because all the drivers made some errors on the dry runs, the errors they made on the wet runs did not signal to them that they were not doing as well; in fact, all drivers thought they had done just as well on the wet runs—even those who had committed the grossest errors—until they were confronted with their scores on paper. The observers who rode with them were under no such illusion. Paul Cooke had been sure that his picked team of top drivers would not respond to alcohol, but when he stepped into a car on the first of the wet runs, "I realized I'd made a mistake."

One driver's blood alcohol level was raised to .15—dangerous beyond argument, but not uncommon as parties are breaking up or bars closing. Point one five (.15) represents the effect, in a 160-pound man, of eight drinks over four hours. At .15, the test driver, who remained aggressively confident throughout, was so obviously intoxicated that his regular observer refused to ride with him: he was grandstanding, cutting tight figure-eights on the tarmac beside the pits. Against the advice of Professor Smith, Paul Cooke volunteered to ride around the course with him, and reported that the difference in his driving was "incredible"—the most outstanding characteristic being his "disregard for his own safety."

Professor Smith emphasized that throughout the wet runs it was the reserve of superlative skill that these top drivers retained, even while intoxicated, that saved them from real trouble; most ordinary drivers subjected to the same tests would have got into an accident.

Professor Smith said in his report that the results of the tests "have a bearing on the legislation proposed by the Canadian Bar Association of .08 per cent as a level at which a driver would be guilty of an offense. These results indicate that this is probably too high a level. Should additional studies support these findings, the permissible level probably should not be higher than .05 per cent. This is in line wth a recommendation by the British Medical Association Advisory Committee in 1960 which indicated that 'The Committee considers the concentration of .05 per cent of alcohol in the blood while driving a motor vehicle is the highest that can be accepted as entirely consistent with the safety of other road users.'

"It is also in line with the recommendation of an International Symposium on Accident and Traffic Medicine whose expert committee resolved 'that in no circumstances should a blood alcohol concentration in excess of .05 per cent be permitted in drivers of motor vehicles on the public highway.'

"This is also in line with the current legislation in Norway, which has been in effect since 1926, of .05 per cent as an offense.

"It is also in line with early studies done in Toronto in 1950 in which it was shown that blood levels of .03-.05 per cent of alcohol began to be a fac-

tor in personal injury accidents."

The Toronto study Professor Smith referred to is one in which he collaborated with Robert Popham, M.A., now associate research director (Behavioral Studies) at this Foundation. The study was called "Blood Alcohol Levels in Relation to Driving" and was published in the October, 1951, issue of the *Canadian Medical Association Journal.* The authors studied police reports, including breath samples, from personal-injury motor vehicle accidents in Toronto over a three-month period. They said their data indicated that the minimum concentrations of alcohol that are important in actual driving situations are in the range of .03 to .05 parts per hundred (.03-.05 per cent).

**Point Zero Eight or Point Zero Five?**

"From the available evidence," they said, "it appears quite reasonable to presume that most drivers are not significantly affected by concentrations of alcohol less than 0.05 parts per hundred and that all drivers with concentrations of 0.15 parts per hundred (.15 per cent) or higher are affected . . . It is suggested that evidence of bloood alcohol concentrations of 0.05 parts per hundred or higher, together with evidence of driving errors, may be sufficient to designate those drivers who may be presumed to be affected by alcohol."

The legislation recommended by the Canadian Bar Association would make unlawful the driving of a motor vehicle by a person with a blood alcohol level to be fixed by the legislation, provided that the level should not be less than .08 per cent. Full text of the proposal was given by Profesesor E. R. Alexander in his article, "Responsibility and Addiction: The Law in Canada,' in the Winter, 1966, issue of *Addictions.*

In material that had to be dropped from that issue because of space limitations, Professor Alexander wrote: "The general membership of the Association rejected this proposal at its annual meeting in September, 1965, but accepted it at the September, 1966, meeting; the Executive Council of the Association then forwarded it to the Minister of Justice, who has it under advisement . . .

"The Canadian Medical Association had previously recommended legislation making it an offense to drive a motor vehicle with a blood alcohol level of more than .05 per cent . . . A special committee of the Canadian Society of Forensic Sciences, following their tenth annual meeting in Ottawa, reported: 'There is indisputable scientific evidence that a car driven by a person who has a blood alcohol level of 0.10 per cent or higher is a danger to others using the roads. However, since impairment of driving occurs in some drivers at a blood alcohol level of 0.05 per cent, this is the highest level that can be accepted as consistent with highway safety.'

"The special committe of the Canadian Bar Association recommended a level of .10 per cent because 'an unreasonably low level would constitute an unwarranted and unjustified invasion of the rights of the individual. On all the material before it, your Committee is of the opinion that such level should not be lower than .1 per cent or 1.0 parts per thousand of alcohol in venous blood.' Apparently the Executive Council of the Association chose the level of .08 per cent as a compromise."

The drinking-driving legislation in Norway is strictly enforced, writes Nils Christie, professor of criminology at the University of Oslo, in the January-February, 1967, issue of *Trans-action,* a publication of the

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# BUD (building up to drink)

*The danger of BUD is greatly diminished if the alcoholic can learn to recognize its onset.*

**BY JORGE VALLES, M.D.**

*BUD (building up to drink)* is a chapter in the book, *How to Live with an Alcoholic,* published in July, 1967 by Essandess Special Editions. The author is director of the Alcoholism Unit, Veterans Administration Hospital, Houston, Texas, and a clinical assistant professor of psychiatry at Baylor University College of Medicine. Dr. Valles' book is available for $1.00 plus 10 cents handling from: Mail Service Department, Simon & Schuster, Inc., 1 West 39th St., New York, N. Y. 10018.

BEFORE going into a discussion of BUD, or Building Up to Drink, we should recall our discussions of previous chapters, particularly those in reference to the emotions and their manisfestations through bodily changes. It is also necessary to bear in mind that the alcoholic is an individual with an emotional supercharge. And we should not lose sight of the deep remorse that constantly plagues the alcoholic.

Upon mention of the word alcoholic we should immediately form a mental picture of a human being in whom everything is at an emotional boiling point, in whom every reaction is part of a continuous confusion, and in whom one simmering emotion is superimposed upon another. We must see him as an individual who is constantly on guard against an attack of anxiety. We must consider that this state of alert in which he lives is in itself the initiating element of his anxiety; thus, every difficulty that arises, no matter how insignificant, is a motive for an emotional reaction on a highly magnified level.

At this point we should call your attention to the alcoholic who appears to be well poised, calm, and aloof. This is only a pose, and that very air of calm is actually a prelude to a tempest. The alcoholic has very little tolerance for stress situations. He is at the mercy of his emotions just as a boat without a rudder is at the mercy of strong waters.

We must bear in mind all that we have said concerning the alcoholic and his emotions if we wish to understand this very important concept of BUD.

There are many inexplicable factors in the behavior of the alcoholic. He may well know from previous experience that if he takes a drink he will go into convulsions and be sent to a hospital for emergency treatment. He assuredly knows that if he takes a single drink he will be utterly powerless to resist taking more drinks and that this will end in an attack of the dreaded DT's. All this has happened to him before.

Why is it that with this bitter knowledge based on his own tormented experience, he cannot control his urge to drink? How is it that he cannot resist this magnet called alcohol, knowing that it leads to the loss of his job, the loss of his happiness, the loss of his family, the loss of his very self? How is it that in sober moments he can be horrified and repelled by

his wretched experiences, and then suddenly fall victim again to the same tormenting master? How is it that while earnestly determined to maintain his sobriety he succumbs again to the lure of alcohol?

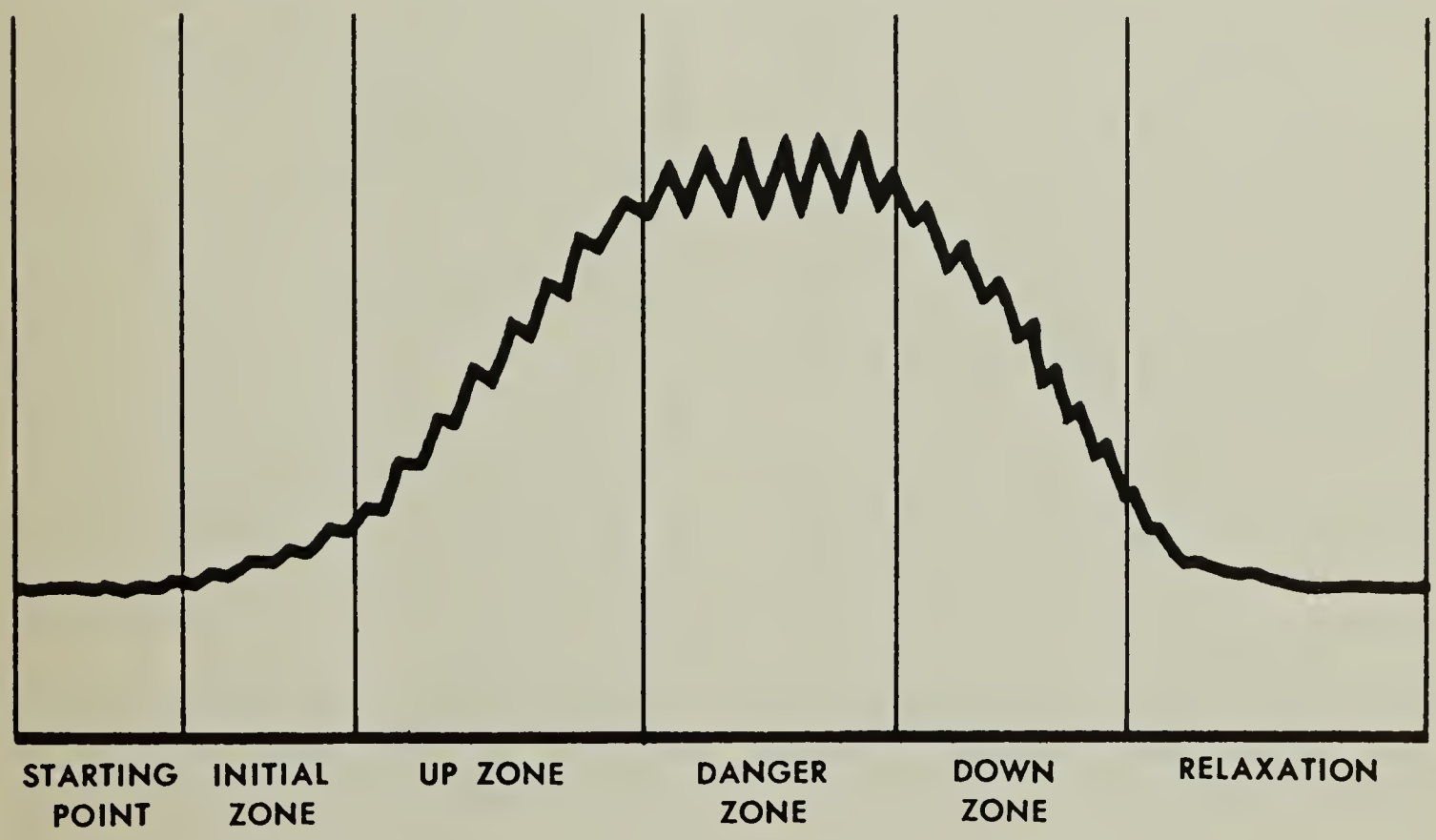
Let us agree that the alcoholic does not deliberately want to suffer the consuming tortures inherent in his addiction. Nor shall we believe that this human being intentionally places his family in jeopardy and purposely inflicts upon them the suffering and anguish that his drinking produces. Neither shall we believe that he actually desires to lose his friends, his dignity as a man, his self-respect, his position in the community. Nor does he blind himself with the pretense that he can escape the price of his drinking. Why, then, does he do it, over and over again?

The alcoholic's wife can usually tell when her husband is getting set for a drinking spell, and she senses it often long before he is aware of it. Through behavior patterns repeated over a period of years, many wives can accurately foretell when their husbands are about to fall into a period of inebriation. One of my patients said to me the other day: "Doctor, my wife could tell when I was going to go out and get drunk by the way I shut the door when I walked into the house."

We may say with some certainty that there is a period when the alcoholic is undergoing some experience that propels him toward drink, despite his sincere and strenuous effort to maintain his sobriety. We may go further and say that we who are on the alert may recognize the onset of this period and condition.

In the foregoing chapters we discussed some of the significant characteristics of the alcoholic. We saw how vital it is to consider his high emotional content. We agreed that when dealing with him it is important to be attentive not only to the words he uses but also to his behaviorisms and gestures. In this spirit of comprehension we shall be able to see the alcoholic realistically.

Close observation will reveal that even before he has had his first drink, he is already in a condition of emotional confusion. Actually, it is "emotional inebriation." That is to say that the alcoholic is already



drunk before the ingestion of alcohol. My experience with many hundreds of alcoholics has convinced me that the alcoholic loses his control and power of volition not when he has had his first drink but *before* taking it

Let us follow this cycle, which we shall call BUD, or Building Up to Drink.

The alcoholic may reach this point of emotional drunkenness by various stages. Usually, however, an alcoholic will follow more or less the same pattern so that this particular cycle is fairly recognizable.

This BUD begins very slowly, in a manner somewhat difficult to note unless one is on guard for it. In fact, it begins so inconspicuously that if one is not aware of this phenomenon it may escape notice. The illustration shows the various stages of this cycle (Page 13).

At the very lowest step on the left, which we have called the starting point, the alcoholic feels somewhat moody, a little irritable, slightly bored, and rather restless. This condition progresses steadily, gaining momentum as it expands.

Now the alcoholic is in what we call the initial zone. Here his irritability is reaching a high pitch and his emotional content is rising. From here he enters the up zone.

That which began feebly and became fairly moderate now deepens and grows more intense. His irritability is uncomfortable to him as well as to those near him. Generally he becomes quarrelsome, raises his voice, and shouts at the slightest provocation, sometimes on the contrary, he becomes exaggeratedly quiet and withdrawn.

Soon symptoms of a physical nature make their appearance; his hands begin to tremble, beads of perspiration accumulate on his forehead and in his hands. He is now approaching a plateau, the danger zone. Here all symptoms, emotional and physical, are highly intensified. He is uncomfortable, unhappy, ebbing in every area. The duration of the danger zone varies according to the alcoholic and depends on the circumstances in which the BUD occurs. It is usually resolved by crisis, that is, by rapid alcoholic inebriation. However, the abatement of this intense stage is possible by *lysis,* a gradual decline of the symptoms, if the alcoholic can be helped through his anxiety and made more comfortable.

After the danger zone he enters what we call the down zone. Here the symptoms begin to diminish, in some cases slowly and in others rather rapidly. After this he passes to the zone of relaxation.

### Learn To Recognize Onset

The importance of BUD cannot be overemphasized. The alcoholic who is trying to maintain his sobriety must be made aware of the manifestations of BUD in all its details. Principally he must learn to recognize the onset of this condition. It is equally important that those who live with him learn to recognize and appreciate all the symptoms of BUD and its gradations.

We must now fix our attention on what we call the beginning point. The BUD may begin in a very casual, almost imperceptible manner. For this reason, the slightest change in the alcoholic's behavior pattern must be regarded as significant and suggestive. We must be alert to the very real possibility that any change may portend the onset of a BUD cycle. This is primary for both the alcoholic and you.

It is important to note also that the BUD may begin its development without the alcoholic's awareness.

The BUD may sneak up on him. and he may find himself well involved before he realizes his condition. In fact, this frequently happens. As a result, it is often very difficult to convince an alcoholic entering this cycle that he is in the precarious position of a possible relapse into drinking.

There are various ways in which the BUD may begin to manifest itself: a change in mood, a headache accompanied by tension, a pain in the shoulder, "a nervous stomach," a recurrent twitch. Sometimes the only symptom is a rather childish way of behaving, a giggly kind of joyousness without any apparent reason, an expression of boredom or weariness, a sudden morbid concern about his health or unemployment or family matters. Through small and seemingly insignificant changes, the BUD may grip the alcoholic before these symptoms convey their meanings to him or to us.

If we are not on guard, the alcoholic's complaints, comments, and behavior will seem reasonable and normal. The fact is that these symptoms are quite natural, but in the alcoholic they may very possibly end disastrously. The sooner we recognize that he is entering a BUD, the easier it will be to control the progress of the up zone. Thus we can delay and perhaps prevent its advance into the danger zone. Every effort should be bent toward that end.

For once he enters the danger zone, a state of acute anxiety sets in. It is urgent that this be alleviated as soon as possible, for if it is not, he will almost inevitably return to drinking. The state of anxiety characteristic of the danger zone must terminate in one way or another, for it is a very painful situation and one for which the alcoholic has no resistance whatever.

We must point out that each one of these zones within the BUD may vary in duration and intensity according to the individual alcoholic and depending on the specific situation. Furthermore, in each of these stages there is a particular way of reaching the final relaxation.

Experience will improve our skills in detecting both the onset and the progress of the BUD.

What can we do to alleviate a BUD? What must the alcoholic do to alleviate a BUD?

The danger of the BUD is greatly diminished if the alcoholic can be taught to recognize its onset. If he can learn to be aware of its starting point, he will understand the significance of the changes occurring within himself, and this in turn will reduce his anxiety or at least prevent it from rising to perilous levels.

Of course it is not always possible to recognize the beginning stages of BUD. In fact it often happens that the alcoholic realizes he is in a BUD only when he has already entered the up zone. In these circumstances the alcoholic must try to concentrate on something outside of himself. Quite often he learns almost instinctively what he must do when he is faced with a BUD. At such times, too, the wife can help the alcoholic in a very direct and practical manner by maintaining her calm and serenity. If a wife reacts with anxiety, she will be unable to conceal her emotion, and this will produce an aggravated condition of anxiety within the alcoholic.

The wife of one of my patients told me this the other day: The husband had been sober for four months. Quite suddenly one evening he began to walk around the TV room, complaining that he felt restless. He

(Continued on page 27)

# TRENDS IN AME

# GOVERNMENTAL

BY WILLIAM J. McCORD, M.P.H.

THE alcoholism movement, as we know it today in America, had its beginning in 1935, some thirty-two years ago with the founding of the fellowship of Alcoholics Anonymous. From a small and quiet beginning, its influence continued to grow as more and more "hopeless" human beings found new hope and a new life through its program. AA was initially viewed with considerable suspicion by the professional groups and existing health and welfare agencies. Now after more than thirty years in existence, AA has been heralded as one of the most significant advances in therapy of the century.

If AA were the seed which started this modern movement, then the activities which followed in the early 1940's must have represented the germination of this new approach—a new movement. These included the establishment of the Yale School of Alcohol Studies, along with the organization of the National Committee for Education on Alcoholism, now the National Council on Alcoholism. The first group of modern state governmental programs was also activated during this period.

The national atmosphere into which all this developed was one shaped by the fact that the great majority of the population approached the alcohol question with ambivalence and apathy, if not open hostility and rejection. The setting, as Bacon has stated, was negatively structured from the beginning, the results of almost ninety years of organized, nationwide conflict about the use of alcohol. The official state agencies, as well as voluntary agencies, emerged into a social vacuum around the problems of alcohol. Prohibition, which was the last great political thrust of the Temperance Movement, was defeated in the thirties—defeated because there was a negative response to it as a symbol, as well as to its restrictions specifically. The rejection was of any controls on alcohol. This reaction became so manifest as to become even a denial of all alcohol problems.

It was a sweeping attitude. This negative attitude, coupled with the fact that there was no existing national consensus or standard regarding the use of beverage alcohol, made for widespread confusion and denial. The people refused to recognize al-

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*State governmental programs are moving toward truly becoming alcoholism programs rather than programs for individual alcoholics.*

# RICAN STATE ALCOHOLISM PROGRAMS

cohol related problems regardless of how obvious they might be. Their response even went beyond this. They were routinely suspicious of anyone or any group which purported to work on any area of the alcohol problems.

Alcoholism, only one of these problems, seemed the only appropriate problem area related to beverage alcohol which the people would tolerate. Certainly, it was the most apparent and least controversial, but even so, the early official and voluntary efforts were governed by rather rigid policies which tried at least to minimize public suspicion and skepticism. This policy of extreme caution was exemplified by such statements as "alcoholism is our only concern," and "we are neither 'wet' nor 'dry,' but only concerned for the alcoholic."

This guarded approach was *initially* necessary, but carried with it certain drawbacks which were not previously anticipated. The disassociation of the movement from the typical wet-dry forces that had been warring for the last century, did not gain wholesale acceptance by the great majority of the people. The approach did manage to open the door slightly, but instead of finding behind that door an eager and interested public, the heralded pronouncements fell on the lay and professional ears alike—ears jaded with apathy, ignorance and cynicism. Allies were few and far between. Suspicion and futility abounded.

The foregoing is obviously an oversimplification, but a necessary one, in view of the long and complex events which were relevant to the movement and also the limitation imposed by the title of this paper.

The legislation which set up the first of the modern state alcoholism programs was passed in the state of Oregon in 1943, although it was not implemented until two years later. The states of Connecticut and Alabama followed closely behind in 1945. These initial programs, administratively were established independently of the established health and welfare community and set the administrative pattern which was to dominate the development of state governmental programs for the next decade. According to Dr. Thomas Plaut, the three major reasons for this type of organizational pattern were:

1. The then lack of interest in alcoholism by state public health, mental health and welfare agencies;
2. the novel and exploratory nature of governmental activity in this field; and
3. the feeling that alcoholism was such a unique and different problem that totally new approaches had to be tried.

Compared with other health and welfare movements, these early state alcoholism programs varied widely. They came into being independently, without any central leadership from official national health and welfare groups. This fact, together with an almost complete void in interprogram communication, led to early state governmental programs without uniform standards, definitions or operating procedures. Some common traits that existed were the relative isolation from other governmental health agencies, a preoccupation with treatment of "the alcoholic," and positively, a tremendous amount of personal dedication and stamina, sometimes bordering on martyrdom.

In August 1949, representatives of a small group of state programs and one provincial program of Canada convened in New Haven, Connecticut. From this meeting came the establishment of the National States Conference on Alcoholism, now known as the North American Association of Alcoholism Programs. This organization was, in the following years, to serve as the major mechanism of communication and coordination of the North American governmental programs. Originally conceived for administrators of the states and provincial governmental agencies to get together annually to share ideas, it has now grown into a vital and aggressive organization, which is playing a major national leadership role. It maintains a central office in Washington, D. C., and its membership is now made up of 43 United States governmental programs, seven provincial programs of Canada, 60 local governmental programs in the United States and Canada, as well as 850 individuals who are professional members.

## *Can the alcoholism movement*

The services provided by these early programs were heavily weighed toward treatment. Though the various states offered inpatient, outpatient or a combination of both types of services, one predominant philosophy was apparent. These facilities and services were mainly available (or at least made attractive) to individuals whose alcoholism had reached such a period of crisis, that the victim was forced to seek help. Persons in the early, as well as the advanced stages of the addiction, were not often reached. This selectivity on the part of treatment resources, I think, was in part the result of the "hitting bottom" concept of Alcoholics Anonymous, which dominated the organizations' early thinking. Today, however, this early concept has altered considerably within this fellowship. Also, this approach by the early treatment programs is understandable since, with limited resources, it was only natural that administrators would want to serve those with the most encouraging prognosis. Positive results were essential. This concentration of resources on a relatively select subgroup of the total alcoholic population served as a successful demonstration and gave validity to the assumption which AA had fostered that alcoholism was not a hopeless condition, and that the voluntary Na-

tional Council on Alcoholism was indeed correct in proclaiming that "alcoholics can be treated and are worthy of treating."

This triumvirate, AA, National Council on Alcoholism and the governmental programs, through the North American Association of Alcoholism Programs, were to, separately and collectively, in the 1950's and 1960's, continue to influence and mold public and professional attitudes, until finally a broad comprehensive concept of alcoholism control was no longer a hollow dream, but a concept poised on the threshold of national reality.

State governmental programs have within the last decade, and in the last five years specifically, come up with some significant new trends. One of the most apparent has been their break from isolation from the remainder of the health and welfare arena. This "ecumenicism" is now a routine and constant theme. The movement itself created the interest and awareness in other agencies and groups, so much so, that the dogged single-purposeness, which has historically characterized the movement is strongly challenged. A real and valid concern is "can the alcoholism movement stay in control of itself," or "does it really have to?"

This trend can be better understood when we look at the administrative structure of the state governmental alcoholism programs. The view has drastically changed. From the initial independent status, the majority of state programs are now located within other governmental agencies. Of the 46 state programs, only nine are still independent, while 37 are a part of a larger governmental agency. The state mental health agency, whether it is independent, as is the case in many states, or whether it too, is a part of a larger health or welfare structure, is currently the prevailing location of the governmental alcoholism effort. Twenty-three state programs are situated there. Thirteen are located directly within the department of public health. The two additional programs are located under the Department of Welfare and the Department of Hospitals respectively.

In most cases, these alcoholism programs, even though under another agency, still maintain a separate divisional identity. Usually, where there was a strong alcoholism program developed prior to consolidation, the effort continues to grow and expand. However, in some cases, where the singular identity of the alcoholism program was diffused, the results have not proven satisfactory.

This trend toward consolidation generally has brought with it both advantages and disadvantages. In assessing the alcoholism control effort, Ernest Shepherd, the Director of the Connecticut State Program, and one of the pioneers of the state alcoholism program movement, stated that the validity of the North American programs, regardless of their settings, would maintain quality service, strong staffs, adequate support and effective programs when they have:

1. in their top administration, leadership and conviction about the importance of the problem of alcoholism and the value of work on it;
2. a core agency or office to which

sufficient funds and authority are assigned; and

3. key specialized competent personnel who can win professional acceptance at significant points in the general services.

Generally, other trends of the 1960's in the state programs are developing. One particularly noteworthy is the "reaching out" trend. Rather than still focusing on that segment of the alcoholic population who, because of social, personal and financial bankruptcy, will seek out help, the movement is making important moves to expand their services to the early stage addict, as well as the "skid road" chronic case. New methods of intervention and early case finding are being used. Industrial programs have led the way in this effort. Their successes have significantly influenced this trend.

### Real Promise

On the other end of the line, the problem of the "skid road" alcoholic has been dramatically highlighted. In two separate cases—now commonly known as the "Driver" and "Easter" decisions—United States Federal Courts have ruled, in essence, that chronic alcoholics cannot be arrested and convicted under existing criminal statutes for their public drunkenness. The impact of these decisions, which are now pending a hearing before the United States Supreme Court, have revitalized and directed attention and concern of government at all levels in alcoholism and, specifically, this long forgotten segment of humanity. There is real promise in the United States today that the "drunk tank" of alcoholism is about to go the same way of the "snake pit" of mental illness, into well-deserved oblivion.

Of paramount importance and an over-riding trend, is that state alcoholism programs are maturing in their basic approaches. They are moving toward truly becoming alcoholism programs, rather than programs for individual alcoholics. The fear and suspicion, both within the movement, as well as within the rest of the health and welfare field, is gradually diminishing. Barriers are becoming bonds.

The movement is becoming more professional—a move which threatens many of the present "professionals" who earned their credentials, not from schooling, but from bitter (and sweet) experience. Many have criticized those with the proper professional credentials for not becoming more a part of the movement—not accepting their responsibility. Now with their new involvement, many of the early critics are now threatened by their interest.

Some of the excitement of being a part of a pioneering effort will be missed in the future. The evangelism which was so much a part of the early movement will subside, but in its place there'll come the stability of time and the security of experience.

If these observations seem too optimistic, then it is only a reflection of my personal feelings. Certainly, this movement has a long way to go, but looking back, it is gratifying to see how far we've come.

In the United States, the next ten years promise to be "The Decade" for the alcoholism movement—a movement born and nurtured on challenge. Still, state governmental programs will face their greatest challenge yet, during this period. The original infant movement, now presently passing through an uneasy adolescence, is poised on the brink of maturity. I, for one, think the challenge will be met.

*Many people have problems with alcoholism even though they are not alcoholics.*

**BY GUY T. ELLIOTT, JR.**
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# Alcoholism: Whose Problem?

I do not drink but I have a problem with alcohol and it concerns me greatly. My problem occurs because I see the suffering, sacrifice and loss that comes from the intake of alcohol. After serving as a staff member of the Alcoholic Rehabilitation Center as admissions officer and group therapist for almost six years, I have seen the consequence of years of haphazard drinking at first hand.

Problems of loss of family, broken homes, loss of children, ruined work history, etc. are a constant face seen at the Alcoholic Rehabilitation Cener. But perhaps the most heartbreaking result seen is the loss of one's mental capacity, a condition known clinically as organic brain damage. I have before me a list of individuals, many of whom I have known personally, who are beyond rehabilitation, no longer acceptable as patients by the Alcoholic Rehabilitation Center because their brains have been destroyed through the consumption of alcohol. In proportion to the total number of patients, there are not many on this list (so few live long enough to be affected), but each is a person and thus counts to someone. Most of them are now confined to mental hospitals as custodial cases. Many of them do not know their names, their families, their homes, nor where they now are. What is this unless it is a type of living death?

There are many others whose health has been ruined by numerous medical problems due to alcohol. A doctor on the staff a few years ago, who had retired after thirty years of general practice, stated frequently that there were to be seen at the Alcoholic Rehabilitation Center more medical problems across the board in one year than were seen by him in thirty years of public practice. This is quite a broad statement, but day to day contact with the problems leads me to know what he meant.

Every week, as patients come in for admission, I see many other people who have a problem with alcohol and they are not alcoholics either. These are the families of our patients. There is a wide reaction by family members to this problem—ranging from motherly protection to open hostility to complete bewilderment. A few years ago, a tenant farmer and his wife came in for his admission. They appeared to be very devoted to each other. He was a spree alcoholic. She was a housewife. They were both uneducated, and had several children. Also, they had suffered three consecutive crop failures. But they were proud people and meant to pull through together. To pay for his admission, they had planned for it for several months and

were finally able to save and borrow the $75.00 needed. When I explained to them that, under such circumstances, we could make arrangements for him to come in without paying, they both said no, they would pay his way. Were they foolish? Maybe not, for they were trying to pull together and would meet this problem together too. Throughout the twenty-eight days here, he worked hard and took every opportunity to probe deeper into alcoholism as it related to him.

There have also been times when a whole flock of people would accompany the patient into the building, and the hostility would be so heavy that it would roll over me in one giant wave. The poor patient appeared to feel about six inches high and out of step with everyone else in the entire world. I have always taken some pleasure in walking out of my office to greet this mass, eyeing each person and then, with great concern ask: "Which one is the patient?" Can you imagine the reaction that took place? The patient soon got his full stature and dignity back and we related man to man as I invited him into my office.

Other shades of human behavior present themselves from time to time. Once a man came into my office who was so drunk that it took two good size men to hold him up. Along with them was a very anxious wife and another lady who turned out to be the patient's mother. They had an appointment and wanted him to be admitted. I explained that the patient had to be sober before we could admit him. The excited wife answered that he had not had any alcohol for over three days and they were positive because he had not been left alone one minute of that time. I questioned them as to what he could have had to make him so drunk. "Why I took the bottle away from him three days ago and he hasn't had anything but beer," answered the wife. Many people do not think of beer as an alcoholic beverage, yet many alcoholics are only beer drinkers.

From time to time I see many sad incidents as well. A middle age couple came in for his admission and I interviewed b o t h together. But throughout the interview I was inwardly concerned about a strange feeling I kept having about the wife. She appeared to be deeply worried about something, more so than the usual seen. Shortly after he was admitted, the wife came back to my office and asked if she could see me for a few minutes. She was invited to have a seat. After some discussion, she stopped in the middle of a sentence and wringing her hands asked: "What will my husband be like thirty days from now?" It turned out that they had been married for seventeen years and he had been a daily drinker throughout their courtship and marriage. She had never seen him when he didn't have some alcohol in his system, although he had never been drunk. Married for seventeen years to a complete stranger, she was *really* worried about what or who she would see four weeks later. How are they doing now? I wish I knew. We see a few pages in a life history and then . . . gone. We are able to keep up with so few of the total.

How important it is for people to look for and expect changes in self-image, outlook, self-esteem, etc., when the patient comes home. If there was no change expected, why come for treatment in the first place? But, the spouse (or family member) has had some time for thought and self-examination, too, which has effected change in them as well. The

changes that take place on both sides are very important if the results are to be favorable.

Many funny events—if we can view actions under stress as funny—take place between patient and family at the time of admission. Several summers ago on a real hot day, and we don't have air conditioning, a patient of small stature and a wife a little on the heavy side appeared at my door. He was invited in and she was asked to have a seat out in the hall. Shortly, two very attractive young ladies (both patients) walked by in summer attire and she eyed them all the way up the hall. She came up out of her chair and was in my office in a flash demanding: "Are they patients here?" "Yes, they are," I answered. Whereupon she grabbed her husband by the collar and out the door they went. The last thing I heard was her pronouncement, "Damned if you are going to stay here."

### A Wide Range of Questions

We get many questions ranging from fundamental questions about alcohol to questions very difficult to answer—if answerable at all. We are asked quite frequently, "How do I know if I am an alcoholic?" Without going into a long discussion over the telephone, I usually answer by asking another question, "Is alcohol giving you any trouble in your daily life, such as with your family, your job, or your relationships with others?" This is usually all that is needed. How often our own value judgments interfere with an appraisal of one who is an alcoholic. To one person, anyone who drinks at all is an alcoholic, while someone else, a person who drinks a pint per day, for instance, would say that an alcoholic is a person who drinks a fifth per day. Meanwhile others, who drink less, are secretly calling the person who drinks a pint a day an alcoholic, too. No wonder there is so much bewilderment and confusion centered around such a question. Occasionally I get a call from a wife or other close family member whose question is classic: "How do I know when it is the right time to *make* my husband volunteer for admisison to the Alcoholic Rehabilitation Center?" Although I have that question asked fairly often it still stumps me. Motivation and volunteerism still bother me a great deal. Of course there are a few questions that stick with you because they are very amusing. Such a question was asked a few months ago and I am still chuckling. "The program at the Alcoholic Rehabilitation Center costs so little how do we know that it is any good?" It is a State supported program, and therefore, does not cost the patient the full amount for treatment

Yes, I have a problem with alcohol, but the problem is in the area of education. How do we find the money, trained personnel, and interest to educate so many about one of the largest diseases affecting our fellowman, and do it as quickly as possible? According to statistics there are about 600,000 people in North Carolina that are directly affected by the life of our alcoholics. Shouldn't we all be concerned?

With this in mind, I believe the philosophy of the Alcoholic Rehabilitation Center is one that needs widespread understanding. Our philosophy, I believe, can be summed up in the belief that alcoholism is a treatable illness from which, with help, the individual can recover and become a valued citizen of his community and the State of North Carolina.

All of us have heard an old saying that life begins at 40. I believe we can use that same saying at the Al-

coholic Rehabilitation Center. We could say that life begins *again* in the early 40's because the average age of our first admissions has stayed in the late 30's to the early 40's. Someone has said that alcoholism is a young person's disease and we certainly have a large percentage of young people as patients. Last year, we admitted, not just one but, three seventeen-year-old alcoholics. But we do admit them in their 60's and 70's as well. And this is their first admission.

Since 10/62, I have been keeping statistics on these two areas: (1) the age of the patient when he started drinking (social drinking) and (2) the age the patient lost control of his drinking (problem drinking). I have checked these areas against what the patient says with what the social history says.

The highest percentage (53%) starts drinking between 16 and 20 years old and the highest percentage (70%) loses control between 20-40 years old. Of the above, 34% were between 20-30 years old and 36% between 30-40 years old.) So loss of control does occur usually at a fairly early age.

Regarding the alcoholic female, we find their loss of control occurring a little later than the male but they generally start drinking about two years later too. I am asked from time to time, is female alcoholism on the increase? I don't know but I do know that the percentage of female admissions has generally risen over the years. However, I don't think this necessarily indicates a rise in drinking or alcoholism but maybe only says to us that treatment for the female is becoming more socially acceptable.

Which brings up the question of whether or not education is being effectively brought to our communi-

***Spouses often say that they***

ties. There have been some very good indicators in the last few years such as the field of jobs. Six years ago very few employers had any company policy outlined to help the alcoholic seek help. Yet today I can think of personal contacts with a dozen businesses that have developed good policy changes in this area. They will offer to keep his job open for him if he will seek treatment. Some will pay the fee for admission, while others will pay for supervisors or above. Some will pay him his salary while he is receiving treatment, while others will give some assistance to the family, etc. But what I think is important is that the alcoholic is being given a chance to make some decision about his future and, at the same time, is still being made aware of the problems alcohol is causing for and to him.

Recent court decisions opened new doors to the legally involved alcoholic. Some are good and some are still quite confusing. But, here again, he is being given a chance to do something, hopefully for the good.

Very often I hear the alcoholic say that he can quit drinking whenever he wants and, anyway, he is not hurting anyone but himself. This defense mechanism is very hard to break through, but cracks in it do begin to occur if we only watch for them. (I think it is important to remember that none of us likes to admit to weaknesses, mistakes, etc.) First of all we already know that he can't quit. This fact is, to the family and other onlookers, the most heartbreaking. I have many people to call or come by the office to talk about the hopelessness of this situation looking for a miracle, and I don't

know any one answer.

The patient's most vulnerable spot may be when he says it hurts no one but himself. I know of many patients who have sought treatment here and worked hard during their stay because they finally saw the effect of their drinking on the lives of their children and/or family.

I remember two examples very distinctly. One man had put up this argument for over fifteen years, and no one had been able to break through. One day the phone rang and a doctor told me that this man was in his office seeking help for the first time. The doctor was really puzzled as to what had happened to change this patient's mind. After he was admitted, I had a chance one day to talk with him. He told me of his daughter who was just beginning to date. He said he came up out of the fog the other night long enough to realize that his daughter was not being picked up by her dates at home. She was going across the street to a neighbor's home or somewhere else. He was furious and waited up for her to come home. He escorted her into the living room and chewed her out about having boyfriends of such disreputable character that she was ashamed to let her parents see them. He said that suddenly he noticed that she was really crying and asked her what was wrong. She answered him by saying, "The reason my dates don't pick me up here is because I don't ever know when you are going to be sober!" "My daughter, whom I really love, was ashamed of her father and not her dates."

The other story involves a man, likewise, who had defended his drinking for about 12 years by the same argument, but this time a hallucination that involved the patient's daughter sent him scurrying to his doctor for an appointment here. He was out in his backyard grilling some chickens on his barbecue grill which was handmade of cement blocks and was of good size. He saw his 8 year old daughter, whom he completely worshipped, come out of the house and run across the yard to him. He picked her up over his head and threw her into the pit. He stood there and listened to her crys and screams for help as well as her begging for him to get her out. He watched her burn completely up. He knew that this could not be real but it was so real. He ran into the house and asked his wife where the daughter was and learned she was in her room playing. He checked and there she was safe and happy. He, too, sought out help because of the effect his drinking was having on him and his family. Very often, it is a very real shock to find this out.

Why do people drink? A good general answer is "to relax and get away from the pressures of life and to feel more comfortable with others." Why does an alcoholic drink? For pretty much the same reasons but with greater and deeper needs. Alcohol is not his basic problem. Of course he gets in trouble and has many problems because of alcohol but just to take it away does not solve his problems either. How often I hear a spouse say that he can tell when his wife or husband is getting ready to pull a drunk. Isn't this a good indication that there has to be some inner compulsions that are coming to a boil that are ready to blow unless some escape outlet is found? This

has to be true, and the alcoholic has learned years ago that there is a substance in a bottle that does the trick.

Very often I find myself looking at an individual and his problems and I catch myslef saying to myself: "Boy, I guess I would have gotten drunk too." This reaction occurs in many different situations. We had a mother a few years ago who was foreign born. She had married a United States serviceman during World War II. She lost all her family but her mother and father during the war. After the war, she and her husband finally managed to get her mother and father over to this country and they were very happy and close. But then came the "black year." In the spring her husband was killed in a truck accident. That summer both of her parents were killed in a car wreck while on vacation. All she had left in the world was her seven year old daughter. Two years later, her daughter ran across the living room with a pencil in her hand. She fell and the pencil went through her right eye into the brain. In two years her entire family was wiped out! I shake my head and still wonder what would have happened to me.

I often find myself surrounded by an atmosphere created by a dominating spouse who marches in my office with the patient, verbally beats the patient to a pulp, answers all the questions I ask, gets furious if I ask him or her to have a seat outside while I talk with the patient, pays the admission fee but really cuts the patient down by pointing out what his drinking and this nonsense treatment is costing them, etc. One husband who brought his wife down for admission gave me an itemized account of all the hospital's and doctor's fees he had had to pay in the last six months because his "no-count, good-for-nothing wife wouldn't leave the bottle alone."

I remember a farmer who ran out of fertilizer just before making the last round on his field. He went to the house to get his truck and go get some more fertilizer. His wife would not let him leave the house until he had sworn on the Bible that he was going after fertilizer and not a bottle. He said, "You know, a bottle was the last thing I had on my mind and I said over and over again all the way to town that I wasn't going to buy a bottle. You know where that truck went? Right to the A.B.C. store, and I came out with a bottle still saying I wasn't going to buy it." How much more like a child could he have been treated? What needs did this man's wife and the woman's husband (above) have that they had to fulfill? Didn't they need some psychiatric treatment too? Right here lies one of the biggest and most misleading problems to the community. We look at the spouse or mother or father and we say: "You poor thing, I don't know how or why you put up with it." And then we jump on this passive-dependent alcoholic with both feet and we help push him or her back a little further into the bottle. I think it is very important that we remember an old observation made about other types of problems —all the blame never lies only on one person's shoulders.

I've seen where parents have made their children stay on the farm or work in the family business when this was the last thing that the child wanted to do with his life. Yet, like some one caught in a spider web, they felt helpless. They didn't want to hurt their parents, and yet they were never able to get out of this maze. So they found in the bottle a dream land, an escape and, yes, even at times the "courage" to finally tell

their parents or other loved ones what they really felt about the situation. This is what the alcoholic is saying essentially when he takes off to parts unknown, but when he sobers up and realizes what he has done he comes back home filled with more guilt and remorse. One patient told me that he had been in every state in the union drinking, but had never been 50 miles away from home sober.

Along these same lines, it is important to point out that we see a high percentage of patients whose loss of control occurred in very close relationship with some severe head injury—auto wreck, etc. So this area of possible brain damage should always be examined. Also, female patients show a high percentage whose problem drinking relates closely to a total hysterectomy or other serious operation. This might mean that, before surgery, more psychological preparation needs to be done to prepare for this loss.

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BUD (building up to drink)

CONTINUED FROM PAGE 15

wanted to go for a walk downtown. The wife immediately recognized that something was happening within him. She then very casually took her husband's arm and led him to the sofa in the living room. "Look," she said, "lie down for a moment and I will massage your back." After a few moments, the alcoholic felt much calmer, and he was able to continue to watch the television program without any further incident.

On the other hand, when an alcoholic openly expressed the fear that he was entering a BUD, his wife reacted by shoutng, "Now you'll go down to your hangout and get drunk again. I know it! And it will all end up as it always does."

Fortunately the man had by then developed sufficient insight and knew that he had to do something concrete. He therefore went to the telephone and called a friend. They chatted for a few moments. This alleviated his anxiety so that he was able to wait calmly until his friend arrived at his home. In this case the mere action of making that phone call, of reaching out beyond himself, saved him from progressing in his BUD. The wife here was of no assistance whatever; on the contrary, she could have propelled him into making a serious mistake.

The alcoholic who knows from previous experience that he cannot control a BUD by himself must be prepared to call someone who would know how to help him in this crisis of anxiety. Here again, Alcoholics Anonymous and Al-Anon can be of inestimable service. Their workers are available at all hours, and their skills are equal only to their abiding interest in the individual alcoholic. (In our work at the hospital, we regard BUD to be of such importance that we have a special twenty-four-hour service, called the BUD Service, specifically organized for discharged patients.)

It is of summary importance to make the alcoholic see that each time he succeeds in overcoming one of his crises, it is a positive step toward the ultimate goal of his complete recovery. He must also be made to understand that when he finds himself with an occasional BUD, this in no way signifies that he is not progressing toward his recovery. Quite the contrary; the fact that he is capable of recognizing the onset of a BUD and has gained the power to control it is clear evidence that he is progressing toward a permanent and secure sobriety.

# community action guidelines

**BY JAY N. CROSS, M.P.H.**
ASSISTANT DIRECTOR OF THE ALCOHOLISM PROJECT
AMERICAN PUBLIC HEALTH ASSOCIATION

IN outlining approaches to alcoholism by public health people it is important to restate principles that apply to the control of any condition of public health importance.

At this point it is unimportant whether alcoholism is considered a disease, an issue, or a condition. Traditionally, the public health team approaches problems other than disease—problems that have relationship and importance to the community health. Among these are programs such as those aimed at the control of vectors or carriers of disease, such as milk sanitation, water pollution control, and inspection of food-preparing establishments. Other public health concerns are those involving radiation, aging and accident prevention. Although special interest groups have attached "disease" labels to some of these entities it would be difficult, in even the broadest context, to give them the traditional definition of disease. Nevertheless, all of these things merit, and in fact demand, attention by the public health team. Therefore, whether alcoholism is considered a symptom of emotional illness, an emotional illness, a social disorder, or another entity, it still falls within the realm of the community health agency.

Efforts aimed at the prevention and control and treatment of alcoholism as a community problem are similar to those used in any other public health approach. Symptoms of the condition are observed in the community, a diagnosis is made, and a treatment or control rationale is proposed, based on these particular symptoms and needs. Programs are then developed to prevent further spread of the condition and to prevent the development of additional cases. Certain questions that occur in disease control must be answered. It must be determined which population groups are most likely to have the infection. The investigator must determine where they are most conveniently and efficiently found. He must be aware of which groups are most apt to be exposed. He must have some knowledge of when, where, how and why they are sub-

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*The public health point of view, historically, has led to some spectacular successes in removal of conditions which have threatened the health of mankind.*

ject to exposure. There must be an inventory of practical and economic control measures and facilities that are available in the community to deal with the problem. The health worker must know which of these are acceptable to the people involved.

As with the chronic diseases, early diagnosis and treatment are important. Hospitalization must be provided. Follow-up and rehabilitation are integral parts of the program. Educational activities directed at the lay public and special professional groups are worthwhile and significant, and custodial or long-term care centers may be needed.

In most communities significant percentages of the population are affected. It is the unusual community in which there are no resources for dealing with alcoholism. Sometimes these can be further developed and their efficiency increased through organizational and educational activities. Most health departments have a definite responsibility for dealing with the problems of alcoholism and already possess the knowledge needed to initiate simple programs in this field.

It may be too much to expect that the public health approach to alcoholism will turn out to be the solution. On the other hand, the public health point of view, historically, has led to some spectacular successes in removal of conditions which have threatened the health of mankind. The public health worker is accustomed to dealing with problems that involve questions of moral judgment, good and evil, reward and punishment. He is expert in ministering to a community with a problem that is based on ignorance, poverty, mental isolation, unshakable tradition or other ingrained social phenomena.

Too often, programs are initiated without careful analysis of the problems to be confronted. Alcoholism programs are no exception. Dedicated persons may rely on nationwide estimates of prevalence of the condition, improperly adapting the statistics to local populations. Even the application of the Jellinek estimation formula to small population is, by that scientist's own admonition, an improper exercise. While the relationship between deaths from cirrhosis of the liver and the rate of alcoholism in a given community may afford a convenient number with which to impress citizens with the importance of the problem—it is a questionable basis upon which to measure the effectiveness of the activities that are initiated in pursuit of its solution.

There are other indices of the problem that, with a little effort, will provide data that will be just as likely to motivate citizens or justify activities. Among sources of these data are:

*General and mental hospital admissions for alcoholism and related*

*conditions; agency load studies (welfare, public health nursing, juvenile and domestic relations courts); arrests for drinking, related offenses; jail commitments; bond forfeitures, probation loads.*

Studies of physician case loads, the number of persons involved in pastoral counseling for drinking problems, and number of problem drinkers found in business and industry are possible in some communities.

In the analysis of the problem, planners must take into consideration the kinds of resources that are available to assist them in meeting the needs of the program. This is particularly important when considering alcoholism, since it is a condition which requires a coordinated attack by a variety of resources. An effort should be made to determine what kinds of resources are presently involved in dealing with alcoholics or alcoholism in each community. The relationships among these organizations or individuals, their patterns of operation, the adequacy and appropriateness of the activities conducted should be explored and described. Agencies whose interest and involvement should be considered exist at the national, state and local levels. State government agencies with interest in alcoholism include the departments of health, welfare, vocational rehabilitation, education, mental health, correction, and hospital facilities. Care-giving institutions at all levels are concerned with alcoholism. Educational facilities ranging from elementary schools to colleges and universities have important functions to perform in teaching about alcoholism. Local government agencies have vital functions in the development of alcoholism control programs—their present involvement and interest must be assessed.

The importance of voluntary organizations in developing alcoholism program activities must not be overlooked. Local councils on alcoholism, mental health associations and other such organizational entities presently provide a large proportion of the informational activities directed to the public, schools, and the families and associates of persons afflicted with alcoholism. There is a reservoir of individuals in most communities who actively work with alcoholics and their families. Included among these persons are physicians, clergymen and lawyers who treat or counsel alcoholics. They provide important functions that should be integrated in the overall program. These individuals probably have rendered services to alcoholics over a longer period of time than any of the special resources that have been instituted.

Once the problem has been analyzed, we are ready to proceed to the next phase of the planning operation —the setting of the goals and objectives upon which services and programs can be founded. In considering alcoholism, the ultimate goal of any large-scale attack on the problem could probably be rather simply stated: either eliminate alcoholism, or to reduce the number of alcoholics to the irreducible minimum. However desirable or appropriate these goals might be, means of attaining them are not clear cut. These ultimate objectives may be more profitably pursued through intermediate goals and objectives.

Public health workers would tend to set intermediate goals for alcoholism programs from two directions of attack—

1. To provide treatment for persons who are already alcoholics; and
2. To prevent alcoholism in those persons who are not alcoholic.

The third step in the planning process is the establishment of the services and activities which make up the programs. There are certain principles that commonly are considered important in meeting community needs in dealing with alcoholism. A program should be broad enough to deal with the great variety of problems within the alcoholism field. The breadth of the program should not necessarily lead it towards uniformity; but instead lead it towards flexibility and ability to cope with each different alcohol problem in the most appropriate way.

The final element of program development is the determination of whether the program succeeded or failed and why. Without evaluation, it is not possible to make needed changes or to apply the experience gained in the conduct of activities to the development of future programs. Program assessment activities range from sophisticated research operations to service personnel asking themselves basic—and often embarrassing—questions about their operations. An evaluative attitude should be an essential part of all program activities.

While the technical and methodological aspects of evaluation often are highly complex, a far greater barrier is the psychological and institutional reluctance of persons to ask the needed questions. Of course, there is some danger that the continuously skeptical person may be ineffective in his work because of his lack of confidence in what he is doing; but there is far greater danger that evaluation of day to day activities is completely avoided. Positive and negative factors, failure and success, advances and set backs must be examined for their impact on future activities and planning.

## POINT ZERO EIGHT

CONTINUED FROM PAGE 11

Community Leadership Project of Washington University, St. Louis, Missouri. After noting that Norway has the lowest legal blood alcohol limit of the Scandinavian countries, Professor Christie writes: "If a driver's blood test measures above the legal minimum (.05 per cent) in Norway he will, typically, draw 21 days in prison and have his license suspended for one year on first offense (more on succeeding offenses) . . .

"More than 2000 persons were imprisoned in Norway in 1963 for drunk driving . . . More people are imprisoned in Norway for drunk driving than for all crimes put together. A sizeable part of the Norwegian people at some time in their lives go through society's most severe ceremony of degradation—imprisonment with criminals."

Referring to the severe drinking-driving laws of all the Scandinavian Countries, Professor Christie writes:

"There is little chance that these laws will be changed—they have strong popular support. Poll after poll show that the people approve of them. Only two groups have serious doubts about them—the drunken drivers themselves and the people who administer the laws. The drunk drivers stay prudently quiet; and the administrators are ambivalent, hampered by a feeling that there are many good things about our present practices.

"For we feel that our present system curtails drinking in general, and drunk driving in particular. Many people don't drive to parties where they expect to find drink, or they don't drink when they get there. Those who do know that they run the risk of getting caught."

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**—Outpatient Treatment Services**

**ASHEVILLE—**

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

**BURLINGTON—**

**Almance County Council on Alcoholism;* R. J. Cook, Executive Director; Room 802, N. C. National Bank Building; Phone 919-228-7053.

†*Alamance County Mental Health Clinic,* 221 Graham-Hopedale Rd.; Phone: 227-6271.

**BUTNER—**

‡*Aftercare Clinic; John Umstead Hospital;* Hours: Mon.-Fri., 9:00 a.m. - 4:00 p.m.

**CHAPEL HILL—**

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

**CHARLOTTE—**

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

**CONCORD—**

†*Cabarrus County Mental Health Clinic,* 102 Church St.; Phone: 786-1181.

**DURHAM—**

†*Department of Psychiatry, Duke University Medical Center;* Phone: 648-8111, Ext. 3416.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

**FAYETTEVILLE—**

†*Cumberland County Mental Health Center;* Cape Fear Valley Hospital; Phone: 484-8123.

**GASTONIA—**

†*Gaston County Mental Health Clinic,* 206 N. Highland St.; Phone: 864-8381.

**GOLDSBORO—**

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12.00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* Durwood Howard, Director; P. O. Box 1598; Phone: 919-735-7033.

†*Wayne County Mental Health Clinic,* 715 Ash St.; Phone: 735-4331.

**GREENSBORO—**

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: 273-8281.

†*Family Service Agency;* 1301 N. Elm St.

**GREENVILLE—**

†*Coastal Plain Mental Health Center,* 1827 West Sixth St.; Phone: 752-7151.

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

**HENDERSON—**

†*Vance County Mental Health Clinic,* County Home Rd.; Phone 492-1176 or 438-4813.

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 158 By-pass W; P. O. Box 1174; Phone: 919-438-3274 or 919-483-4702.

**HENDERSONVILLE—**

*Alcohol Information Center;* S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

†*Henderson County Health Department;* Phone: 692-4223.

**HIGH POINT—**

†*Family Service of High Point,* 113 Gatewood Ave.; Phone: 883-1709 or 833-2119.

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

**JAMESTOWN—**

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

**LAURINBURG—**

†*Scotland County Mental Health Clinic,* 1304 Biggs St.; Phone: 276-7360.

**MORGANTON—**

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

**Burke County Council on Alcoholism;* Grady Buff, Educational Director; 211 N. Sterling St.; Phone: 704-433-1221.

**NEW BERN—**

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

**†Psychiatric Social Service,* Craven County Hospital; Phone: 919-638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

**NEWTON—**

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

**PINEHURST—**

*Sandhills Mental Health Center;* Box 1098; Phone: 295-6851.

**RALEIGH—**

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

**SALISBURY—**

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: 633-3616.

**SANFORD—**

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

**SHELBY—**

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

**SOUTHERN PINES—**

**Moore County Alcoholism Program;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

**WADESBORO—**

†*Anson County Health Department;* Phone: 694-2516.

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

**WILMINGTON—**

†*Southeastern Mental Health Center,* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; P. O. Box 1435; Phone: 919-736-7732.

**WILSON—**

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

**Wilson County Council on Alcoholism;* W. H. Jennings, Director; Room 208, 116 S. Goldsboro St.; Phone: 919-237-0585.

**WINDSOR—**

**Bertie County Alcohol Information and Service Center;* Rev. Donald Dawson, Director.

**WINSTON-SALEM—**

**†Alcoholism Program of Forsyth County;* Robert Charlton, Educational Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

†*Department of Psychiatry, Bowman Gray School of Medicine;* Phone: 725-7261.

†*Forsyth County Mental Health Unit,* Seventh and Woodland; Phone: 722-0364.

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